STANDARD FORM NO. 64

Office Memorandum • UNITED STATES GOVERNMENT

ALEXANDER - in the physician's records! A. Clayton

TO: Alek CLAYTON

DATE: 13 August 1963

Date and Sign

Using alias

FROM: [redacted]

#3: I was asked, by the doctor to sign one more blanco form 89. A. Clayton

SUBJECT: Medical Appointment

19 August

A medical examination has been scheduled for Monday/ afternoon at 2:00 PM (1400 hrs.) at the office of Dr. [redacted] whose address is: [redacted]

Attached are (2) copies of the form 89. One completed copy you take with you to the doctors office when you appear for the examination- the other completed copy you can give to [redacted] who will bring it back to me. The second copy gets placed in your file as a matter of record.

Please follow instructions for filling out the form 89 very carefully.

DO NOT GIVE NAMES ON QUESTION 35. LIST SURGERY, ILLNESSES OR AILMENTS - NO NAMES OF DOCTORS

Standard Form 89
(Rev. Aug. 1960)
PROMULGATED BY
BUREAU OF THE BUDGET
CIRCULAR A-2I

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
CLAYTON, ALEXANDER.	X	X
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
X	X	19 Aug 1963.

7. SEX	8. RACE	9. TOTAL YRS. GOVT. SERVICE MILITARY / CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	CAUCASIAN	X	X	X

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
13 Sep 1904	ESTONIA	X

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
X	X

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by description of past history, if complaint exists)

GENERALLY GOOD; SOME DETERIORATION OF HEARING, LEFT EAR.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER			INNER LIMENIS	54
MOTHER			OLD AGE	77
SPOUSE	54	GOOD		
BROTHERS AND SISTERS	65	UNKNOWN		
	63	GOOD in general		
			WAR CASUALTY	42
			WAR CASUALTY	38
	54	GOOD in general.		
CHILDREN	32	GOOD		
	24	GOOD		

19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR HUSBAND OR WIFE:

YES	NO	(Check each item)	RELATION(S)
	✓	HAD TUBERCULOSIS	
	✓	HAD SYPHILIS	
	✓	HAD DIABETES	
	✓	HAD CANCER	
	✓	HAD KIDNEY TROUBLE	
	✓	HAD HEART TROUBLE	
✓		HAD STOMACH TROUBLE	FATHER
✓		HAD RHEUMATISM (Arthritis)	MOTHER
	✓	HAD ASTHMA, HAY FEVER, HIVES	
	✓	HAD EPILEPSY (Fits)	
	✓	COMMITTED SUICIDE	
	✓	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
✓		SCARLET FEVER, ERYSIPELAS		✓	GOITER		✓	TUMOR, GROWTH, CYST, CANCER		✓	"TRICK" OR LOCKED KNEE
	✓	DIPHTHERIA		✓	TUBERCULOSIS		✓	RUPTURE		✓	FOOT TROUBLE
	✓	RHEUMATIC FEVER		✓	SOAKING SWEATS (Night sweats)		✓	APPENDICITIS		✓	NEURITIS
	✓	SWOLLEN OR PAINFUL JOINTS		✓	ASTHMA		✓	PILES OR RECTAL DISEASE		✓	PARALYSIS (Inc. infantile)
✓		MUMPS		✓	SHORTNESS OF BREATH		✓	FREQUENT OR PAINFUL URINATION		✓	EPILEPSY OR FITS
✓	✓	WHOOPING COUGH		✓	PAIN OR PRESSURE IN CHEST		✓	KIDNEY STONE OR BLOOD IN URINE	✓		CAR, TRAIN, SEA, OR AIR SICKNESS
✓		FREQUENT OR SEVERE HEADACHE		✓	CHRONIC COUGH		✓	SUGAR OR ALBUMIN IN URINE		✓	FREQUENT TROUBLE SLEEPING
	✓	DIZZINESS OR FAINTING SPELLS		✓	PALPITATION OR POUNDING HEART		✓	BOILS		✓	FREQUENT OR TERRIFYING NIGHTMARES
✓		EYE TROUBLE		✓	HIGH OR LOW BLOOD PRESSURE		✓	VENEREAL DISEASE		✓	DEPRESSION OR EXCESSIVE WORRY
	✓	EAR, NOSE OR THROAT TROUBLE	✓		CRAMPS IN YOUR LEGS		✓	RECENT GAIN OR LOSS OF WEIGHT		✓	LOSS OF MEMORY OR AMNESIA
	✓	RUNNING EARS		✓	FREQUENT INDIGESTION	✓		ARTHRITIS OR RHEUMATISM		✓	BED WETTING
	✓	CHRONIC OR FREQUENT COLDS		✓	STOMACH, LIVER OR INTESTINAL TROUBLE		✓	BONE, JOINT, OR OTHER DEFORMITY		✓	NERVOUS TROUBLE OF ANY SORT
	✓	SEVERE TOOTH OR GUM TROUBLE		✓	GALL BLADDER TROUBLE OR GALL STONES		✓	LAMENESS		✓	ANY DRUG OR NARCOTIC HABIT
✓		SINUSITIS		✓	JAUNDICE		✓	LOSS OF ARM, LEG, FINGER, OR TOE		✓	EXCESSIVE DRINKING HABIT
	✓	HAY FEVER		✓	ANY REACTION TO SERUM, DRUG OR MEDICINE	✓		PAINFUL OR "TRICK" SHOULDER OR ELBOW		✓	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)						22. FEMALES ONLY: A. HAVE YOU EVER—			B. COMPLETE THE FOLLOWING:	
✓		WORN GLASSES		✓	ATTEMPTED SUICIDE			BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
	✓	WORN AN ARTIFICIAL EYE		✓	BEEN A SLEEP WALKER			HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
	✓	WORN HEARING AIDS		✓	LIVED WITH ANYONE WHO HAD TUBERCULOSIS			BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
	✓	STUTTERED OR STAMMERED		✓	COUGHED UP BLOOD			HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
	✓	WORN A BRACE OR BACK SUPPORT		✓	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION			HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY	

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU (Check one)
X	X	X	☐ RIGHT HANDED ☑ LEFT HANDED

16—62289-1

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT.	
	✓	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.	
	✓	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	✓	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	✓	D. OTHER MEDICAL REASONS (*If yes, give reasons*)	
	✓	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCES?	
	✓	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)	
	✓	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)	
	✓	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)	
	✓	32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (*If yes, describe and give age at which occurred*)	
	✓	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)	
✓		34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)	measles.
✓		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, and details*)	Dry mass of skin. Change of Rx glasses. ARTHRITIS.
	✓	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)	
	✓	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)	
	✓	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability*)	
	✓	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)	

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
CLAYTON, ALEX	Alex Clay Dos 15 Aug 1963

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers in items 20 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

16—92289-1 ☆ U.S. GOVERNMENT PRINTING OFFICE : 1952—O-213344